LONG TERM CARE SERVICES IN NURSING FACILITIES

SECTION 2

TABLE OF CONTENTS

1 LONG TERM CARE PROGRAM FOR MEDICAID CLIENTS RESIDING IN A NURSING FACILITY

SECTION 2 provides information on coverage of long term care (LTC) for Medicaid clients in Nursing Facilities (NFs) and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR). For information regarding other Medicaid requirements and policies, refer to SECTION 1 of this Medicaid Provider Manual.

Nursing Facility services are mandated under the Medicaid program. ICF/MR services are optional services.

Institutions primarily for the care and treatment of mental disease (IMDs) are not reimbursable for persons over age 21 and under age 65.

1 - 1 List of Contacts

For more information on a specific policy or procedure, please contact the responsible agency as indicated below.

Provider Manual Distribution	Bureau of Medicaid Operations (801) 538-6155 Toll-free: 1-800-662-9651
Medicaid Financial Eligibility	Bureau of Eligibility Services (801) 538-6494 Richard Nelson
PreAdmission/Continued Stay Review (Form 10A)	Bureau of M/M Program Certification and Resident Assessment (801) 538-6158 1-800-662-4157
Pre-admission Screening and Annual Resident Review (PASARR)	Bureau of M/M Program Certification and Resident Assessment (801) 538-6158 1-800-662-4157
Facility Survey	Bureau of M/M Program Certification and Resident Assessment (801) 538-6157

Nurse Aide Training and Competency Evaluation Program	Bureau of Managed Health Care (801) 538-6636 RueDell Sudweeks
LTC Turnaround Document	Bureau of Medicaid Operations (801) 538-6155 Toll-free: 1-800-662-9651
Reimbursement	Bureau of Financial Services (801) 538-6440 Blaine Goff

1 - 2 Hospice and Home-Based Long Term Care

Other long term care programs in the Utah Medicaid Program are the Home and Community-Based Services Waiver Programs, Hospice Care, Personal Care Services, and Home Health Services. Contact Medicaid Information to obtain information regarding these programs and a provider manual.

1 - 3 Appropriate Placement

The cost of care in a nursing facility must be less than the cost of care for alternative, non-institutional services in order for the Department to approve nursing facility coverage for an applicant. The Department may not consider the availability of Medicaid reimbursement for alternative services as a factor in determining the relative costs of alternative services. Unless the cost of care through alternative, non-institutional services is higher than the cost of care in a nursing facility, the Department will deny nursing facility coverage for an applicant whose health, rehabilitative, and social needs may reasonably be met through alternative non-institutional services.

Reference: R414-502-3 of the Utah Administrative Code (UAC)

2 DEFINITIONS

" Act " means the federal Social Security Act.

" Ancillary Charges " means any charges made by a medical provider, not included as part of nursing facility coverage.

" Applicant " means any person who requests assistance under the medical programs available through the Division.

"Certified program" means a nursing facility program with Medicaid certification.

" Code of Federal Regulations " (CFR) means the publication by the Office of the Federal Register, specifically Title 42, used to govern the administration of the Medicaid program.

" Crossover Payments " means payments made first by Medicare, then by Medicaid. When a client is eligible for both Medicare and Medicaid, claims are sent to Medicare. After the Medicare payment is made, Medicaid covers any remaining bill. A payment may or may not be made depending on services covered and the amount paid by Medicare.

" Department " means the Department of Health.

" Director " means the Director of the Division of Health Care Financing within the Department of Health.

" Division " means the Division of Health Care Financing within the Department of Health

" Executive Director " means the Executive Director of the Department of Health.

" Family Income " means the monthly amount a Medicaid recipient must pay from his own funds toward the cost of nursing facility care. (Box 9 on The Long Term Care Turnaround Document.)

"Medicaid certification" means the right to Medicaid reimbursement as a provider of a nursing facility program shown by a valid federal Health Care Financing Administration (HCFA) Form 1539 (7-84).

" Medicaid Rate " means the patient reimbursement rate paid to a nursing facility for an individual eligible for the Utah Medicaid Program.

" Medical assistance program " or " Medicaid program " means the state program for medical assistance for persons who are eligible under the state plan adopted pursuant to Title XIX of the federal Social Security Act, as implemented by Title 26, Chapter 18, UCA.

" Medical or hospital assistance " means services furnished or payments made to or on behalf of recipients eligible for the Utah Medicaid Program.

"Nursing facility" means any Medicaid participating NF, SNF, ICF, ICF/MR, or a combination thereof, as defined in 42 USC 1396r(a) (1988), 42 CFR 440.150 and 442.12 (1993), and UCA 26-21-2(15).

"Nursing facility program" means the personnel, licenses, services, contracts, and all other requirements that must be present for a nursing facility to be eligible for Medicaid certification as detailed in 42 CFR 442.1 through .119, 483.1 through .480, and 488.1 through .64 (1993), which are adopted and incorporated by reference.

"Physical facility" means the building(s) or other physical structure(s) where a nursing facility program is operated.

" Private Pay Rate " means the rate an individual not eligible for Medicaid would pay for long term care in the facility.

" Resident " means an individual eligible for the Utah Medicaid Program who resides in a nursing facility.

"Service area" means the boundaries of the distinct geographical area served by a type of certified program, the Department to determine the exact area, based on fostering price competition and maintaining economy and efficiency in the Medicaid program.

" Utah Administrative Code " (UAC) means the compilation of rules promulgated by state agencies under delegation of authority from the Utah Legislature.

" Utah Code Annotated " (UCA) means the compilation of legal statutes enacted by the Utah Legislature.

3 PROVIDER ENROLLMENT

3 - 1 Medicare Skilled Nursing Facility Certification

All skilled nursing facilities must be certified for Medicare participation as a condition of Medicaid certification. Authority: R414-27 of the Utah Administrative Code (UAC).

3 - 2 Certification of New Nursing Facilities

Medicaid limits reimbursement of nursing facility programs to programs certified as of January 13, 1989. In addition:

A. The Department shall not process initial applications for Medicaid certification or execute initial provider agreements with nursing facility programs, except as authorized by Chapters 3 - 21 or 3 - 22.

B. The Department shall not reinstate Medicaid certification for a previously certified provider whose Medicaid certification expires, or is terminated by action of the federal or state government, except as authorized by Chapters 3 - 21 or 3 - 22

C. The Department shall not execute a Medicaid provider agreement with a certified program that moves its nursing facility program to a different physical facility, except as authorized by Chapters 3 - 21 or 3 - 22.

Authority for this subsection is found in Sections 26-18-2.3, 26-1-5, 26-1-30(2)(a), (b), and (w) and 26-18-3 of the Utah Code Annotated (UCA) , and R414-7A of the Utah Administrative Code (UAC).

The purpose of this subsection is to control the supply of Medicaid nursing facility programs. The oversupply of nursing facility programs in the state has adversely affected the Utah Medicaid program and the health of the people within the state. This subsection continues the prohibition against certification of new nursing facility programs that has been in place since January 13, 1989. This subsection clarifies that prohibition and sets up policy to deal with the possible future need for additional Medicaid nursing facility programs in a service area. The July 1990 Report of the Governor's Task Force on Long Term Care recommended continuation of this prohibition. The Task Force concluded that "Market entry into the nursing facility industry should be regulated to allow supply to come more in line with demand". This subsection also supports the policy of the Department to direct new resources into community based alternatives.

3 - 21 Authorization to Renew, Assign, or Transfer Medicaid Certification

A. The Department may renew Medicaid certification of a certified program if the program, without any lapse in service to Medicaid recipients, has its nursing facility program certified by the Department at the same physical facility.

B. The Department may certify a new nursing facility program if a certified program transfers all of its rights to Medicaid certification to the new nursing facility program and the new program meets all of the following conditions:

1. The new nursing facility program operates at the same physical facility as the previous certified program.
2. The new nursing facility program complies with 42 CFR 442.14 (1993).
3. The new nursing facility program receives Medicaid certification within one year of the date the previously certified program ceased to provide medical assistance to a Medicaid recipient.

C. The Department may certify a previously certified program that moves to a different physical facility and meets all of the following conditions:

1. On the last day that the certified program provided medical assistance to a Medicaid recipient in the original physical facility, it meets all applicable requirements to be a certified program.
2. The different physical facility is in the same service area.
3. The time between which the certified program ceases to operate in the original physical facility and begins to operate in the different physical facility is not more than three years.
4. The provider operating the certified program gives written assurances satisfactory to the Executive Director or his designee that:
   a. no third party has a legitimate claim to operate a certified program at the previous physical facility;
   b. the certified program agrees to defend and indemnify the Department against any claims made by third parties who may assert a right to operate a certified program at the previous physical facility; and
   c. if a third party is found, by a final agency action of the Department after exhaustion of all administrative and judicial appeal rights, to be entitled to operate a certified program at the original physical facility, the certified program shall voluntarily comply with item D of this subsection (3 - 21).

D. Upon a finding being made as set forth in item C. 4. c. of this subsection (3 - 21), the certified program shall immediately surrender its Medicaid certification, cease billing Medicaid for all services to Medicaid recipients, and arrange for the orderly discharge of Medicaid recipients to a facility satisfactory to the Department. If the third party found to be entitled to operate a certified program at the original physical facility requests Medicaid certification, and the previously certified program has surrendered its Medicaid certification, the Department shall treat the request as a transfer of all its rights under item B of this subsection (3 - 21).

3 - 22 Certification of Additional Nursing Facility Programs

The Department may certify additional nursing facility programs if the Executive Director or his designee determines that there is insufficient capacity at certified programs in a service area to meet the public need.

A. The Department may certify an additional nursing facility program only when two conditions are met:

1. After 30-day notice to the Department of Human Services of the Department's finding that there is insufficient capacity at certified programs in a service area to meet the public need, the Department of Human Services cannot demonstrate that community-based services can meet the public need; and

2. After the close of the 30-day notice to the Department of Human Services and a separate 30-day notice to all certified programs operating in the service area, the certified programs operating in the service area cannot demonstrate that they have tangible plans to add additional capacity to their nursing facility programs to meet the public need.

B. If community-based services and existing certified programs operating in the service area cannot demonstrate that they can meet the public need, the Department may select an additional nursing facility program through a request-for-proposal process.

1. Each proposal must include sufficient information to allow the Department to evaluate and rank it among all proposals according to the criteria in item 2 below, as well as other information that the Department solicits in its request-for-proposals. The Department shall reject all proposals that offer to operate for a reimbursement rate higher than that paid to similar certified programs.

2. The Department shall evaluate and select from among the proposals based on maintaining price competition, economy, and efficiency in the Medicaid program; the ability of the proposed nursing facility program to deliver quality care; and how quickly the proposed nursing facility program can begin to operate.

C. If a nursing facility program that the Department selected under the request-for-proposal process fails to undertake the necessary steps to become Medicaid certified or fails to begin to provide medical assistance to Medicaid recipients as represented in its proposal, the Department may reject that nursing facility program, and either select the next ranked nursing facility program or solicit new proposals without again complying with the requirements of item A. in this subsection (3 - 22).

D. If, after certifying an additional nursing facility program, the Executive Director or his designee determines that there is sufficient capacity at certified programs in a service area to meet the public need, the limitations set out in items A, B and C in this subsection (3 - 22) control the certification of nursing facility programs.

3 - 3 Provider Contract

A. With respect to agreements between the Medicaid agency and each provider furnishing services under the plan:

1. For all providers, the requirements of 42 CFR 431.107 and 42 CFR Part 442, Subparts A and B (if applicable) are met.
2. For providers of NF services, the requirements of 42 CFR Part 483, Subpart B, and section 1919 of the Act are also met.
3. For providers of ICF/MR services, the requirements of participation in 42 CFR Part 483, subpart I are also met.

B. The Provider Contract is Appendix A.

NOTE: The new provider contract in Appendix A will be put in use beginning July 1, 1999. The provider contract for each facility will be completed in conjunction with the facility's FY2000 certification survey conducted by the Bureau of Medicare/Medicaid Provider Certification and Resident Assessment.

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4 REQUIREMENTS FOR NURSING FACILITIES

4 - 1 Nurse Aide Training and Competency Evaluation Program

Any individual working in a nursing facility as a nurse aide for more than four months on a full-time basis must have successfully completed a nurse aide training and competency evaluation program or competency evaluation program approved by the state. The Omnibus Budget Reconciliation Acts of 1987, 1989, and 1990 prohibits facilities from employing a nurse aide for more than four months on a full-time basis who has not successfully completed a nurse aide training and/or competency evaluation program approved by the state. The text of the *Nursing Aide Training and Competency Evaluation Program Provider Manual* is Appendix B.

4 - 2 Free Choice of Providers

A. Except as provided in paragraph B, the Medicaid agency assures that a recipient eligible for Medicaid may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is qualified to perform the services, including an organization that provides these services or arranges for their availability on a prepayment basis.

B. Paragraph A does not apply to services furnished to a recipient --
   1. Under an exception allowed under 42 CFR 431.54, subject to the limitations in paragraph 3, or
   2. Under a waiver approved under 42 CFR 431.55, subject to the limitations in paragraph 3, or
   3. Enrollment of an individual eligible for medical assistance in a primary care case management system described in Section 1915(b)(1) of the Social Security Act, a health maintenance organization, or a similar entity shall not restrict the choice of the qualified person from whom the recipient may receive emergency services or services under Section 1905(a)(4)(c).

4 - 3 Leave of Absence

Definition: A leave of absence day is defined as any day during which the resident is absent from a facility for therapeutic or rehabilitative purposes and does not return by midnight of the same day.

A. Reimbursement for a Nursing Facility Resident Temporarily Admitted to Hospital

A nursing facility certified under Title XIX will not receive payment for any day or days for which a bed is held while a resident is temporarily in a hospital. The facility will receive payment for the day of admission to the facility, but not for the day of discharge to the hospital.

B. Reimbursement for Temporary Leave of Absence for Reasons Other than Admission to Hospital

1. Nursing Facility
   a. Payment for therapeutic or rehabilitative leave of absence shall be limited to 12 days per calendar year for each resident of a nursing facility.
   b. Payment for additional leave of absence days may be authorized only with prior approval from the Division of Health Care Financing. The facility's request for prior approval must be accompanied by appropriate and adequate documentation and must include approval of the additional leave days by the resident's attending physician and/or the interdisciplinary team as appropriate to meet and support the resident's plan of care.

2. Intermediate Care Facility for the Mentally Retarded
   a. Payment for therapeutic or rehabilitative leave of absence shall be limited to 25 days per calendar quarter for each resident of an Intermediate Care Facility for the Mentally Retarded.
   b. Payment for additional leave of absence days may be authorized only with prior approval from the Division of Health Care Financing. The facility's request for prior approval must be accompanied by appropriate and adequate documentation and must include approval of the additional leave days by client's attending physician and/or the interdisciplinary team as appropriate to meet and support the resident's plan of care.

3. Any therapeutic or rehabilitative leave of absence must be pursuant to a written order by the resident's attending physician, appropriately and adequately documented in the progress notes of the resident's chart and identified as rehabilitative leave by the physician and/or the interdisciplinary team as meeting and supporting the resident's plan of care.

4. All leave of absence days must be reported on the monthly billing form.

4 - 4 Notice of Financial Rights and Covered Services

The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid, of the following:

A. The items and services that are included in nursing facility services under the Medicaid State Plan and for which the resident may not be charged;

B. Other items and services the facility offers for which the resident may be charged and the amount of charges for those services.

The facility must inform each resident when changes are made to the items and services specified above.

The Medicaid flat rate reimbursement shall cover the services specified in Appendix G, Utah State Plan, Attachment 4.19D, Section 400.

4 - 5 Resident Personal Funds

Medicaid clients are permitted to retain a fixed monthly amount for personal needs. For most individuals the amount is $45 a month. For individuals receiving a VA Aid and Attendance Payment, the amount is $90. This monthly allowance is reserved strictly for a resident to use as wished for personal reasons and is protected as a resident right in accordance with Section 1919(F)(7) of the Social Security Act and 42 CFR 483.10.

4 - 51 Protection of Resident Personal Funds

A. The resident has the right to manage his or her financial affairs, and the facility may not require residents to deposit their personal funds with the facility.

B. Upon written authorization of a resident, the facility must hold, safeguard, manage and account for the personal funds of the resident deposited with the facility, as follows:

   1. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts and that credits all interest earned on resident's funds to that account. In pooled accounts there must be a separate accounting for each resident's share.

   2. The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest bearing account, or petty cash fund.

C. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

   1. The accounting system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

   2. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.

D. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less that the SSI resource limit for one person and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

E. Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.

F. If the facility sells or leases the business, it must:

   1. Provide the buyer or lessee with a written statement of all of the residents' monies and properties being transferred;

   2. Obtain a signed receipt from the new owner or lessee before the sale or lease is final; and

   3. Provide each resident's legal guardian, representative payee, or other person the resident authorized to manage his personal funds, a written accounting of all funds held by the facility before any transfer of ownership. The new owner or lessee shall assume full liability for all residents' personal needs accounts.

G. The facility must notify the Social Security Administration office to have a representative payee appointed for residents who do not have a legal guardian, representative payee, or other authorized individual to manage their personal needs funds.

H. The facility must serve as a temporary representative payee for the resident until the representative payee is appointed.

I. The facility must give any benefits to the resident either personally or through the resident's personal need fund unless there is a written authorization from the resident or legal guardian to do otherwise. This includes resident entitlements from Social Security Supplemental Income, government and private pensions, Veterans Administration, and other similar entitlement programs.

J. The facility must allow the resident to access his funds for at least one hour during business hours.

K. Upon request, the facility must return funds to the resident from an outside interest-bearing account within one business day.

L. The facility may deposit the resident's Social Security check into the facility's bank account if the resident's personal needs allowance portion of the resident's check is transferred to the resident's account on the same day.

4 - 52 Limitations on Charges to Resident Personal Funds

The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid and not requested by the resident. The facility may not require a resident to request any item or service as a condition of admission or continued stay.

When the resident requests a noncovered item or service for which a charge will be made, the facility must inform the resident that there will be a charge and the amount of the charge. There must be an agreement in writing between the facility and the resident regarding the service and the amount to be paid by the resident prior to the resident receiving the noncovered service. Without written agreement, the facility may not bill the resident. Refer also to SECTION 1, GENERAL INFORMATION, Chapter 6 - 8, Billing Patients, and 6 - 9, Exceptions to Billing Patients.

A. During the course of a covered Medicaid stay, the facility may not charge a resident for routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to the following:

1. Hair hygiene supplies;
2. Comb and brush;
3. Bath soap;
4. Disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection;
5. Razor;
6. Shaving cream;
7. Toothbrush;
8. Toothpaste;
9. Denture adhesive;
10. Denture cleanser;
11. Dental floss;
12. Moisturizing lotion;
13. Tissues;
14. Cotton balls;
15. Cotton swabs;

16. Deodorant;

17. Incontinence care and supplies

18. Sanitary napkins and related supplies;

19. Towels and washcloths;

20. Hospital gowns;

21. Over the counter drugs;

22. Hair and nail hygiene services;

23. Bathing;

24. Basic personal laundry.

B. With written agreement, categories of items and services that the facility may charge to residents' funds if they are requested and if payment is not made by Medicaid, include:

1. Telephone;

2. Television/radio for personal use;

3. Personal comfort items, including smoking materials, notions and novelties, and confections;

4. Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid;

5. Personal clothing;

6. Personal reading matter;

7. Gifts purchased on behalf of a resident;

8. Flowers and plants;

9. Social events and entertainment offered outside the scope of the activities program required by 42 CFR 483.15;

10. Noncovered special care services such as privately hired nurses or aides;

11. Private room, except when therapeutically required (for example, isolation for infection control);

12. Specially prepared or alternative food requested instead of the food generally prepared by the facility, as required by 42 CFR 483.35.

4 - 6 Privacy Act Notification Statement

Each facility is required to provide a Privacy Act Notification Statement to each new resident at the time of admission. The statement explains the release of certain data about each resident to the Bureau of Medicare/Medicaid Program Certification and Resident Assessment for data collection and analysis. The required statement follows this chapter of the manual.

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Privacy Act Notification Statement

The Health Care Financing Administration (HCFA) is authorized to collect these data by Sections 1819(f), 1919(f), 1819(b)(3)(A), and 1864 of the Social Security Act. The purpose of this data collection is to aid in the administration of the survey and certification of Medicare/Medicaid long term care facilities and to study the effectiveness and quality of care given in those facilities. This system will also support regulatory, reimbursement, policy, and research functions. This system will collect the minimum amount of personal data needed to accomplish its stated purpose.

The information collected will be entered into the Long Term Care Minimum Data Set (LTC MDS) system of records, System No. 09-70-1516. Information from this system may be disclosed, under specific circumstances, to: (1) a congressional office from the record of an individual in response to an inquiry from the congressional made at the request of that individual; (2) the Bureau of Census; (3) the Department of Justice; (4) an individual or organization for a research, evaluation, or epidemiological project relating to the prevention of disease of disability, or the restoration of health; (5) contractors working for HCFA to carry out Medicare/Medicaid functions, collating or analyzing data, or to detect fraud or abuse; (6) an agency of a State government for purposes of determining, evaluating and/or assessing overall or aggregate cost, effectiveness, and/or quality of health care services provided in the State; (7) another Federal agency to fulfill a requirement of a Federal statute that implements a health benefits program funded in whole or in part with Federal funds or to detect fraud or abuse; (8) Peer Review Organizations to perform Title XI or Title XVIII functions, (9) another entity that makes payment for or oversees administration of health care services for preventing fraud or abuse under specific conditions.

You should be aware that P.L. 100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government to verify information by way of computer matches.

Collection of the Social Security Number is voluntary; however, failure to provide this information may result in the loss of Medicare benefits provided by the nursing home. The Social Security Number will be used to verify the association of information to the appropriate individual.

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4 - 7 Family Income

This chapter provides instructions regarding the amount of family income to be collected by nursing facilities and the submission of family income to the appropriate State agency. There are six subsections in this chapter.

A. Determination of Family Income
B. Collection of Family Income
C. Reporting Changes in Family Income
D. Special Situations
E. Remitting Income to the Office of Recovery Services
F. Definitions

Note: In this chapter, boxes 5, 8, 9 and 23 refer to the numbered boxes on the *Long Term Care Turnaround Document*. A copy of this document is included with this manual. See Appendix C.

A. Determination of Family Income

The Medicaid eligibility worker determines the amount of income the Medicaid client must pay to the facility in order to be eligible for Medicaid. This amount is called " Family Income ". The amount appears in box 9 on the Long Term Care Turnaround Document. When there are questions or information concerning Medicaid patients that may affect the amount of family income, continued Medicaid eligibility, or the collection of family income, please contact the local Medicaid worker.

It is important to be aware that Medicaid policy states that the eligibility worker must calculate family income based on the gross entitlement amount of the client's income. Sometimes the entitlement amount differs from the amount actually received by the client. In determining family income, the eligibility worker cannot allow a deduction from the entitlement amount for any amounts withheld because of a previous overpayment or court-ordered support payment.

The deduction allowed from the gross entitlement amount varies according to the client's marital status and the length of time the client is expected to stay in the facility.

1. For married clients and long term stay (more than six months) clients, the following deductions apply:
   a. A personal needs allowance of $45, or $90 for some people who receive a VA pension, and
   b. The allowable income deductions, such as the cost of medical insurance and income to be sent to the spouse at home.

2. An unmarried client is not expected to contribute as much countable income to the facility if a medical doctor expects the client to stay in the facility for six months or less. The following deductions apply:
   a. Basic maintenance needs allowance. (As of March 1999, the allowance is $382.)
   b. The cost of medical insurance.

B. Collection of Family Income

The facility is responsible for collecting the family income amount (box 9 on the LTC Turnaround Document) from the client. This amount is the portion of the cost of care the client must pay to the facility. Since this amount is owed to the facility by the client, a State agency cannot be involved in the collection process.

C. Reporting Changes in Family Income

A facility is required to immediately report to the Medicaid eligibility worker all changes that may affect the client's family income amount. This includes, but is not limited to, the gross entitlement amount, medical premiums paid, length of stay, and marital status.

D. Special Situations Concerning Family Income

This subsection addresses collection of family income in the following circumstances:

1. Income Between the Private Pay and Medicaid Rates
2. Income above the Private Pay Rate
3. Medicare and Medicaid Crossover Payments
4. Death of Recipient, And Family Income Is Greater Than the Product of The Daily Medicaid Rate Multiplied by The Countable Days of Institutionalization
5. Recipient Is Discharged, and the Family Income Changes for The Month of Discharge
6. Short Term Hospitalization
7. Long Term Hospitalization

The policy references the form **Sending Family Income to ORS** (Office of Recovery Services). This form is included with this manual and follows this chapter.

If you have questions concerning the collection of family income as explained in this subsection, please contact the Medicaid eligibility worker, or you may call Medicaid Information and ask for the supervisor for Nursing Home Medicaid eligibility workers.

1. Income Between the Private Pay and Medicaid Rates

When the family income in box 9 on the LTC Turnaround Document is more than the Medicaid rate in box 8 but less than the facility's monthly private pay rate, please take three actions:

A. Collect the family income (box 9).

B. Keep enough of the family income to cover the Medicaid rate.

C. Submit the remaining income to Recovery Services with the form **Sending Family Income to ORS**. Mark 1 on the form to indicate the income is between the private pay and Medicaid rate.

2. Income above the Private Pay Rate

If the family income in box 9 on the LTC Turnaround Document is more than the facility's monthly private pay rate, take two actions:

A. Collect from the resident enough income to cover the family income (box 9).

B. Contact the Medicaid eligibility worker. He or she will confer with you to determine if it is in the resident's best interest to seek Medicaid coverage for ancillary services. Please assist the worker in establishing the anticipated cost of ancillary charges and the resident's cost for long term care at the Medicaid rate.

1. Resident eligible for coverage of ancillary charges.
   a. The Medicaid worker determines the amount of family income owed to the State. (The resident is allowed to keep more than the standard personal needs allowance.)
   b. The resident must remit the correct amount of income to the Medicaid Office before he or she is actually eligible for Medicaid for that month.
   c. The Medicaid worker will notify you when the resident is eligible for Medicaid to cover ancillary charges only. Once the resident pays the monthly amount owed to the State, Medicaid will cover medical costs other than the nursing facility rate.

2. Resident NOT eligible for coverage of ancillary charges.
   a. If the resident is no longer eligible for Medicaid, the Medicaid case is closed.
   b. If the resident does not pay the monthly amount owed to the State, the Medicaid case is closed.
   c. When the resident is not eligible for Medicaid, the facility may charge the private pay rate.

3. Medicare and Medicaid Crossover Payments

A. When Medicare and Medicaid crossover payments cover part of the Medicaid rate, and family income covers the remainder of the rate, take two actions:

1. Collect the entire amount of family income amount in box 9 on the LTC Turnaround Document.
2. Keep enough of the family income amount in box 9 on the LTC Turnaround Document to cover the remainder of the Medicaid rate (box 8).
3. Submit all remaining family income to Recovery Services with the form **Sending Family Income to ORS**. Mark line 2 of the form to identify the refund as one which results from Medicare/Medicaid coverage.

B. When Medicare and Medicaid crossover payments cover all of the Medicaid rate, take two actions:

1. Collect the entire amount of family income in box 9 on the LTC Turnaround Document.
2. Submit all family income to Recovery Services with the form **Sending Family Income to ORS**. Mark 2 on the form to identify the refund as one which results from Medicare/Medicaid coverage.

4. Death of Recipient, and Family Income Is Greater Than the Product of the Daily Medicaid Rate Multiplied by the Countable Days of Institutionalization

When the recipient dies, and the family income amount in box 9 on the LTC Turnaround Document is greater than the per diem rate (box 5) for the total days billed (box 23), follow these instructions:

A. Collect the entire amount of family income. Please explain to the responsible party that:

1. There may be bills for medical care other than the nursing facility charge, and all family income must be applied toward payment of these medical costs.
2. The responsible party may request a refund by contacting the Medicaid eligibility worker. The refund amount will be the family income minus the costs of all medical care, including the nursing facility charge. Refer to subsection F. of this chapter, Refunds of Income Sent to ORS.
3. Of the family income collected, the facility is entitled to keep the product of the per diem rate (box 5 on the turnaround document) multiplied by total days billed (box 23).
4. Send the remaining family income to Recovery Services with the form **Sending Family Income to ORS**. Mark 3 on the form to identify the payment as one resulting from death or discharge of the recipient.

B. If the responsible party refuses to pay the entire amount owed, contact the Medicaid worker and report the amount you have collected. If you have collected more than the Medicaid rate, follow the directions in item A above.

5. Recipient Is Discharged, and the Family Income Changes for The Month of Discharge

If the client is single or has a spouse who is also a resident of a medical institution, the client may be entitled to keep a larger portion of family income for the month of discharge. The Medicaid agency requests that the facility assist in refunding to the client as soon as possible the difference between the original family income collected and the correct amount. The client needs this money to live on during the month of discharge.

A. The facility can help in two ways:

1. Notify Medicaid.

   You can help by expeditiously notifying the Medicaid worker that the client has left the facility. The Medicaid worker will compute a new family income amount, which may be less than the original amount collected.

2. Make Refund.

   After the worker tells you the correct family amount, please refund the difference between the original amount collected and the correct amount to the client. Make this refund as soon as possible.

There are two exceptions to the refund process:

1. If refunding income to the client creates a hardship for your facility for any reason, let the Medicaid worker know. The worker can request the refund from the Division of Health Care Financing. The Division will correct your nursing facility payroll as necessary.
2. Any refunds computed for the month of discharge after the month following the month of discharge will be handled through the Division's internal procedures.

B. Family Income Collected Exceeds Nursing Facility Bill

In some cases, after all adjustments are made, the amount collected by the facility will still exceed the amount owed to the facility. If so, take two actions:

1. Of the family income collected, keep the product of the per diem rate (box 5 on the LTC Turnaround Document) multiplied by total days billed (box 23).
2. Send the remaining family income to Recovery Services with the form **Sending Family Income to ORS**. Mark 3 on the form to identify the payment as one resulting from the discharge of the client.

6. Short Term Hospitalization

Short term hospitalization is any month during which the recipient is a resident of a LTC facility, is discharged to a hospital, and then returns or is expected to return to the facility by the end of the next month. The facility should take three actions:

A. Collect the family income in box 9 on the LTC Turnaround Document.

B. Of the family income collected, the facility is entitled to keep the product of the per diem rate (box 5) multiplied by the total days billed (box 23).

C. Send the remaining family income to Recovery Services with the form **Sending Family Income to ORS**. Mark 4 on the form to identify the payment as one resulting from short term hospitalization.

7. Long Term Hospitalization

Any hospitalization which does not meet the short term definition is long term. In long term hospitalizations, take four actions:

A. Notify the Medicaid worker that the client is in the hospital for a long term stay.

B. Collect the family income amount for the month the client is discharged to the hospital.

C. Calculate and keep the cost of care, which is the product of the per diem rate (box 5 on the LTC Turnaround Document) multiplied by the total days billed (box 23).

D. Send the remaining family income to Recovery Services with the form **Sending Family Income to ORS**. Mark 5 on the form to identify the payment as one resulting from long term hospitalization.

Family Income for Subsequent Months of Hospitalization

Generally, the Medicaid Office will collect family income for months after the initial month the client is in the hospital. However, collection can be negotiated between the Medicaid Office and the facility. For example, when the facility is the payee for the client, and it is expected that the client will return to the facility, it may be simpler for the facility to continue collecting the family income. During these months, send any family income collected to the local Medicaid Office with the form **Sending Family Income to ORS**. Mark 5 on the form to identify the payment as one resulting from long term hospitalization.

E. Remitting Income to the Office of Recovery Services

When sending family income to Recovery Services, **make checks payable to 'Office of Recovery Services'**. Send the check to the following:

ATTN: Mary Besst, Team 85
Department of Human Services
Office of Recovery Services, Medicaid Section
P.O. Box 45025
Salt Lake City, Utah 84145-5025

Attach a copy of the form **Sending Family Income to ORS** to the check. This form appears on the next page. Place an X on the appropriate line to inform ORS of the reason for the refund.

F. Refunds of Income Sent to ORS

If the client or family asks for a refund of any family income that has been or should be sent to ORS, instruct them to contact the local Medicaid worker. The only exception to this is found in subsection D - 4 of this chapter, "Death of Recipient, And Family Income Is Greater Than the Product of The Daily Medicaid Rate Multiplied by The Countable Days of Institutionalization."

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UTAH MEDICAID PROGRAM

NURSING HOME PROGRAM

SENDING FAMILY INCOME TO OFFICE OF RECOVERY SERVICES (ORS)

When it is appropriate to submit income to ORS, make checks payable to ORS and send to:

Attention: Mary Besst, Team 85
Department of Human Services
Office of Recovery Services, Medicaid Section
P.O. Box 45025
Salt Lake City, Utah 84145-5025

Attach this form to the refund check and identify the reason for the refund by placing an X in the appropriate space.

1. _____ **Income Between the Private Pay and Medicaid Rate**

2. _____ **Medicare and Medicaid Cross-Over Payments**

3. _____ **Recipient Dies or is Discharged and the Family Income is Greater than the Product of the Daily Medicaid Rate Multiplied by the Countable Days of Institutionalization.**

4. _____ **Short Term Hospitalization**

5. _____ **Long Term Hospitalization**

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4 - 8 Nursing Facility Refunds to Medicaid Clients Who Paid the Private Pay Rate

When a nursing facility resident is or becomes eligible for Medicaid, the resident's financial liability is limited to the monthly client contribution to cost of care required by Medicaid. The client contribution, also called the Family Income amount, is determined by the Medicaid eligibility worker. The Family Income amount is stated in the Medicaid notice of eligibility and on the Turn Around Document (TAD). See also Chapter 4 - 7, *Family Income*.

If the resident has paid or been billed at the private pay rate for the month and then becomes eligible for Medicaid for the same month, the facility may owe the client a refund. The facility must refund to the client the difference between the amount paid and the Family Income amount. The facility may bill Medicaid for any cost of care not covered by the Family Income amount.

The facility must refund any excess income paid because it is required to accept the Medicaid reimbursement amount as payment in full. The Medicaid reimbursement is the client's contribution to cost of care *plus* the remainder of the Medicaid per diem payment. Residents eligible for Medicaid must not be billed in excess of the required contribution to cost of care.

4 - 9 Drug Recycling Program For Medicaid Clients Residing in a LTCF or Nursing Home

Nursing Homes and other LTCF will perform a monthly accumulation and inventory of patient medications that have been discontinued and/or left behind by clients. These medications must be returned to the pharmacy which in turn will credit their value to the Division. Logs of returned drugs must be maintained by both the LTCF and the pharmacy. The Division will provide the forms for the log book. Scheduled drugs and opened vials, tubes, etc. are not to be recycled.

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5 PUBLICATIONS FOR CLIENTS

Publications are available to all facilities for distribution to persons considering admission to a nursing facility or currently residing in a facility. Obtain publications from the Division of Health Care Financing, Bureau of Eligibility Services, or the local Medicaid worker. Appendix D contains the text of the publications listed below.

- *Nursing Home Information*: *May we be of service to you?*
- *Assessment of Assets*
- *Estate Recovery Information Bulletin*

6 PREADMISSION SCREENING AND CONTINUED STAY REVIEW

R414-501 of the Utah Administrative Code (UAC) defines the preadmission and continued stay review process. The text of R414-501 is reprinted below:

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.

R414-501. Preadmission and Continued Stay Review.

R414-501-1. Introduction and Authority.

This rule implements 42 USC 1396r(b)(3), (e)(5), and (f)(6)(B), and 42 CFR 456.1, 456.271, 456.331, 456.333, and 456.370 through 456.372, by requiring the evaluation of each resident's need for admission and continued stay in a nursing facility. 42 USC 1396r, requirements for nursing facilities, and 42 CFR 483, requirements for states and nursing facilities, are adopted and incorporated by reference.

R414-501-2. Definitions.

In addition to the definitions in R414-1-1, the following definitions apply to Rules R414-501 through R414-503:

(1) "Activities of daily living" are defined in 42 CFR 483.25(a)(1), and further includes adaptation to the use of assistive devices and prostheses intended to provide the greatest degree of independent functioning.

(2) "Categorical determination" means a determination made pursuant to 42 CFR 483.130 and ATTACHMENT 4.39-A of the State Plan.

(3) "Code of Federal Regulations (CFR)" means the 1993 edition unless otherwise noted.

(4) "Continued stay review" means a periodic, supplemental, or interim review of a resident performed by a Department health care professional either by telephone or on-site review.

(5) "Discharge planning" means planning that ensures that the resident has an individualized planned program of post-discharge continuing care that:

(a) states the medical, functional, behavioral and social levels necessary for the resident to be discharged to a less restrictive setting;

(b) includes the steps needed to move the resident to a less restrictive setting;

(c) establishes the feasibility of the resident's achieving the levels necessary for discharge; and

(d) states the anticipated time frame for that achievement.

(6) "Health care professional" means a duly licensed or certified physician, physician assistant, nurse practitioner, physical therapist, speech therapist, occupational therapist, registered professional nurse, licensed practical nurse, social worker, or qualified mental retardation professional.

(7) "Level I screening" means the preadmission identification screening discussed in R414-503-3.

(8) "Level II evaluation" means the preadmission evaluation and annual resident review for serious mental illness or mental retardation discussed in R414-503-4.

(9) "Medicaid resident" means a resident who is a Medicaid recipient.

(10) "Mental retardation" is defined in 42 CFR 483.102(b)(3) and includes "persons with related conditions" as defined in 42 CFR 435.1009.

(11) "Nursing facility" is defined in 42 USC 1396r(a), and also includes an intermediate care facility for the

mentally retarded as defined in 42 USC 1396d(d).

(12) "Resident" means a person residing in a Medicaid-certified nursing facility.

(13) "Serious mental illness" is defined in 42 CFR 483.102(b)(1).

(14) "Skilled care" means those services defined in 42 CFR 440.40(a).

(15) "Specialized rehabilitative services" means those services provided pursuant to 42 CFR 483.45 and R432-150-22.

(16) "Specialized services" means those services provided pursuant to 42 CFR 483.120 and ATTACHMENT 4.39 of the State Plan.

(17) "United States Code (USC)" means the 1993 edition unless otherwise noted.

(18) "Working days" means all days except Saturdays, Sundays, and recognized state holidays.

R414-501-3. Preadmission Authorization.

(1) A nursing facility shall perform a preadmission assessment when admitting an applicant, including an applicant who will be reclassified from Medicare skilled care to Medicaid nursing facility care, or who is currently funded from another source but anticipates applying for Medicaid within 90 days of admission, and has been referred by a mental health center or civilly committed to the mental health system. Preadmission authorization is not transferable from one nursing facility to another.

(2) A nursing facility may perform a preadmission assessment on any other person who applies for nursing facility care.

(3) A nursing facility must obtain prior approval from the Department before admitting an applicant. A request for prior approval may be in writing or by telephone and shall include:

(a) the name, age, and Medicaid eligibility of the applicant;

(b) the date of transfer or admission to the nursing facility;

(c) the date of the surgical procedure or traumatic incident, if any, that caused the need for care;

(d) the reason for acute care inpatient hospitalization or emergency placement, if any, and the care and services needed;

(e) the applicant's current functional and mental status;

(f) the established diagnoses;

(g) the medications and treatments currently ordered for the applicant;

(h) the projected level of care placement and an evaluation of alternative care resources and support services previously used, currently in use, and available through the community and family;

(i) the name of the individual requesting the prior approval;

(j) the Level I screening, except the screening is not required for admission to an intermediate care facility for the mentally retarded; and

(k) the Level II determination, if required by the Department.

(4) If the Department gives prior approval, the nursing facility shall submit to the Department within five working days a preadmission transmittal for the applicant, and shall begin preparing the complete contact for the applicant. The complete contact is a written application containing all the elements of a request for prior approval plus:

(a) the preadmission or continued stay transmittal;

(b) a signed release of information;

(c) a history and physical;

(d) the physician's orders;

(e) a nursing assessment;

(f) a social evaluation;

(g) a discharge plan;

(h) a resident assessment instrument completed no later than 14 calendar days after the resident is admitted to a nursing facility; and

(i) the completed comprehensive plan of care that includes measurable objectives and timetables to treat medical and psychosocial needs that are identified in a comprehensive assessment of significant impairments in the resident's functional capacity and his capabilities to perform daily life functions.

(5) When a Medicaid resident is admitted to a hospital, the Department may not require preadmission authorization when the Medicaid resident returns to the original nursing facility not later than three consecutive days after the date of discharge from the nursing facility. If the readmission occurs four or more days after the date of discharge from the nursing facility, the nursing facility shall complete the preadmission authorization process again. However, if a Medicaid resident returns to a nursing facility for the mentally retarded within the three day period and may require skilled care or services, then the nursing facility shall immediately request prior approval from the Department.

(6) The Department shall reimburse a nursing facility for the five days allowed in Subsection R414-501-3(6)(c) if the Department, without full assessment, gives prior approval for a resident who is an immediate placement.

(a) An immediate placement shall meet one of the following criteria:

(i) The resident exhausted acute care benefits or was discharged by a hospital;

(ii) A Medicare fiscal intermediary changed the resident's level of care, or the Medicare benefit days terminated and there is a need for continuing services reimbursed under Medicaid;

(iii) Protective services in the Department of Human Services placed the resident for care;

(iv) A tragedy, such as fire or flood, has occurred in the home, and the resident is injured, or an accident leaves a dependent person in imminent danger and requires immediate institutionalization;

(v) A family member who has been providing care to the resident dies or suddenly becomes ill;

(vi) A nursing facility terminated services, either through an adverse certification action or closure of the facility, and the resident must be transferred to meet his medical or habilitation needs; or

(vii) In the previous placement, the resident presented a clear danger to himself, others, or property.

(b) The Department shall deny an immediate placement unless the Level I screening is completed and the Department determines a Level II evaluation is not required, or if the Level II evaluation is required, then the Level II evaluation is completed and the Department determines the applicant qualifies for placement in a nursing facility and Medicaid reimbursement. The three exceptions to this requirement are when the applicant is a provisional placement for less than seven days, the applicant has previously been screened and the determinations will be reviewed on his annual resident review, or when the placement is after an acute hospital stay and the physician certifies that the placement will be for less than 30 days.

(c) Prior approval for an immediate placement shall be effective for no more than five working days. During that period the nursing facility shall submit a preadmission transmittal, and shall begin preparing the complete contact for the applicant. If the nursing facility fails to timely submit the preadmission transmittal, the Department may not make any payments until the Department receives the preadmission transmittal and the nursing facility again complies with all preadmission requirements.

(7) If the Department determines that an applicant requires the level of care provided in a nursing facility, the Department shall assure that the appropriate state case manager informs the applicant or his legal representative of any feasible alternatives available under the home and community based services waiver and

gives him the choice of either nursing facility or home and community based services.

(8) If a nursing facility accepts a resident who elects not to apply for Medicaid coverage, and the nursing facility can prove that it gave the resident or his legal representative written notice of Medicaid eligibility and preadmission requirements, then the resident or legal representative shall be solely responsible for payment for the services rendered. However, if a nursing facility cannot prove it gave the notice to a resident or his legal representative, then the nursing facility shall be solely responsible for payment for the services rendered during the time when the resident was eligible for Medicaid coverage.

(9) If the Department determines an applicant is not eligible for Medicaid, or a third-party payor is responsible for the services to be provided to an applicant, then the Department may defer final action on a contact until:

(a) the applicant becomes eligible for Medicaid reimbursement, at which time the contact will be approved as of the date of the prior approval;

(b) the applicant fails to pursue Medicaid reimbursement within 150 days of the initial contact;

(c) the Department refers the applicant to an alternative placement; or

(d) the applicant dies.

(10) The Department shall refer medically ineligible applicants to appropriate health-related agencies when the preadmission assessment identifies such a need.

(11) The Department shall deny payment to a nursing facility for services provided before the earliest of (a) the date of the verbal prior approval, (b) the date postmarked on the envelope containing the written application, or (c) the date the Department receives the written application.

R414-501-4. Continued Stay Review.

(1) The Department shall conduct a continued stay review to determine the need for continued stay in a nursing facility and to determine whether the resident has shown sufficient improvement to implement discharge planning.

Within 60 days after the Department authorizes Medicaid reimbursement for a Medicaid resident, the Department shall commence the continued stay review. This review must be completed no later than the last day of the calendar month in which it is due.

(2) If a question regarding placement or level of care for a Medicaid resident arises, the Department may request additional information from the nursing facility. If the question remains unresolved, a Department health care professional may perform a supplemental on-site review. The Department or the nursing facility can also initiate an interim review because of a change in the Medicaid resident's condition or medical needs.

(3) A nursing facility shall make appropriate personnel and information reasonably accessible so the Department can conduct the continued stay review.

(4) A nursing facility shall inform the Department by telephone or in writing when the needs of a Medicaid resident change to possibly require discharge, a different level of care, or a change from the findings in the Level I screening or Level II evaluation. A nursing facility shall also inform the Department of newly acquired facts relating to the resident's diagnosis, medications, treatments, care or service needs, or plan of care that may not have been known when the Department determined medical need for admission or continued stay.

(5) The Department shall deny payment to a nursing facility for services provided to a Medicaid resident who, against medical advice, leaves a nursing facility for more than two consecutive days, or who fails to return within two consecutive days after an authorized leave of absence. A nursing facility shall report all such instances to the Department. The resident shall complete all preadmission requirements before the Department may approve payment for further nursing facility services.

R414-501-5. General Provisions.

(1) The Department is solely responsible for approving or denying a preadmission or continued stay authorization for payment for nursing facility services provided to a Medicaid resident. The Department is ultimately responsible for determining the level of care for a Medicaid resident in a nursing facility. If a nursing facility complies with all preadmission and continued stay requirements for a Medicaid resident then the Department shall provide coverage consistent with the state plan.

(2) If a nursing facility fails to comply with all preadmission or continued stay requirements, the Department shall deny payment to the nursing facility for services provided to the applicant. The nursing facility is liable for all expenses incurred for services provided to the applicant on or after the date the applicant applied for Medicaid. The nursing facility may not bill the applicant or his legal representative for services not reimbursed by the Department due to the nursing facility's failure to follow preadmission or continued stay rules.

(3) If the Department denies a claim, then the Department shall comply with 42 CFR 431.200 through 431.246, and also send written notice to the nursing facility administrator, the attending physician, and, if possible, the next-of-kin or legal representative of the applicant. If the Department denies a claim, then the nursing facility can resubmit additional documentation not later than 60 calendar days after the date the Department receives the initial preadmission or continued stay transmittal. If the nursing facility fails to submit additional documentation that corrects the claim deficiencies within the 60 calendar day period, then the denial becomes final and the nursing facility waives all rights to Medicaid reimbursement from the time of admission until the Department approves a subsequent request for authorization submitted by the nursing facility.

(4) The Department adopts the standards and procedures for conducting a fair hearing set forth in 42 USC 1396a(a)(3) and 42 CFR 431.200 through 431.246, which are incorporated by reference. Those laws are implemented in Title 63, Chapter 46b and in R410-14.

R414-501-6. Grace Days.

The Department grants to each nursing facility 30 grace days in each fiscal year (July 1 to June 30). A nursing facility may use these grace days if an otherwise eligible recipient is admitted to the nursing facility or returns to the nursing facility after a hospital admission and the nursing facility fails to comply with preadmission or continued stay rules and is thus denied payment by the Department. The nursing facility may use these grace days for one recipient or many recipients. To use these grace days the nursing facility shall contact the Department in order to change the payment document in the computer system. The Department shall keep a record of the grace days used by each nursing facility and shall provide this information to a nursing facility upon request.

R414-501-7. Safeguarding Information of Applicants and Residents.

(1) The Department adopts the standards and procedures for safeguarding information of applicants and recipients set forth in 42 USC 1396a(a)(7) and 42 CFR 431.300 through 431.307, which are incorporated by reference.

(2) Standards for safeguarding a resident's private records are set forth in Section 63-2-302.

R414-501-8. Free Choice of Providers.

Subject to certain restrictions outlined in 42 CFR 431.51, 42 USC 1396a(a)(23) requires that recipients have the freedom to choose a provider. A recipient who believes his freedom to choose a provider has been denied or impaired may request a hearing from the Department, as outlined in 42 CFR 431.200 through 431.221.

KEY: medicaid
1994
26-1-5
26-18-3
63-46a-7(1)(a)

6 - 1 Preadmission/Continued Stay Inpatient Care Transmittal (Form 10A)

The Preadmission/Continued Stay Inpatient Care Transmittal (commonly known as Form 10A) is the document used in the nursing preadmission and continued stay approval process. Form 10A contains data elements that will be entered into the computer system and generate the initial billing turnaround document for the approved level of care. Errors in the completion of Form 10A will result in delay and/or nonpayment of services approved for payment. Form 10A and instructions are included with this manual as Appendix E.

6 - 2 Patient/Resident Release of Information

The Patient/Resident Release of Information form is for authorization from the resident, or the responsible party and/or next of kin. The release permits the Resident Assessment Section to review the medical and psycho-social information necessary and to assess care and service needs relating to the proposed placement in the nursing facility or ICF/MR specified in the Form 10A. A copy of this form is on the next page of this manual.

Department of Health

Division of Health Systems Improvement

Bureau of Facility Review

Patient Release of Information

Patient Name _____

I D # _____

Facility Name _____

Provider # _____

PATIENT / RESIDENT Release of Information:

I hereby authorize the release to PATIENT ASSESSMENT SECTION, information relative to my medical and social status for the purpose of assessing my care/service needs in relationship to the proposed placement in the nursing care facility specified in this document.

If placement in a nursing care facility is not recommended at this time, I also authorize the release by PATIENT ASSESSMENT SECTION to other State agencies of pertinent information from my file for the purpose of developing implementing and appropriate alternative placement to meet my medical/social care and service needs.

SIGNATURE_____
_____

Patient/Resident Date

SIGNATURE_____
_____

Next of Kin and/or responsible party (If applicable) Date

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6 - 3 Nursing Facility Levels of Care

R414-502 of the Utah Administrative Code (UAC) defines the levels of care provided in nursing facilities. The text of R414-502 is reprinted below:

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.

R414-502. Nursing Facility Levels of Care.

R414-502-1. Introduction and Authority.

This rule defines the levels of care provided in nursing facilities.

R414-502-2. Definitions.

The definitions in R414-1-1 and R414-501-2 apply to this rule.

R414-502-3. Approval of Level of Care.

(1) In determining whether the applicant has mental or physical conditions that can only be cared for in a nursing facility, the Department shall document that at least two of the following factors exist:

(a) Due to diagnosed medical conditions, the applicant requires at least substantial physical assistance with activities of daily living above the level of verbal prompting, supervising, or setting up;

(b) The attending physician has determined that the applicant's level of dysfunction in orientation to person, place, or time requires nursing facility care; or

(c) The medical condition and intensity of services indicate that the care needs of the applicant cannot be safely met in a less structured setting and alternatives have been explored and are not feasible.

(2) Unless the cost of care through alternative non-institutional services is higher than the cost of care in a nursing facility, the Department shall deny nursing facility coverage for an applicant whose health, rehabilitative, and social needs may reasonably be met through alternative non-institutional services. The Department may not consider the availability of Medicaid reimbursement for alternative services as a factor in determining the relative costs of alternative services.

(3) The Department shall deny coverage for a Medicaid resident until the Department approves the specific level of care based upon the severity of illness, intensity of service needed, anticipated outcome, and setting for the service. The Department shall deny coverage for a more intense level of care if, as a practical matter, the applicant's care and treatment needs can be met at a less intense level of care. Levels of care, ranked in order of intensity from the least intense to the most intense, are:

(a) nursing facility III care;

(b) nursing facility II care;

(c) nursing facility I care; and

(d) intensive skilled care.

R414-502-4. Criteria for Nursing Facility III Care.

The following criteria must be met before the Department may authorize Medicaid coverage for an applicant at the nursing facility III care level:

(1) A physical examination was completed within 30 days before or seven days after admission;

(2) A registered nurse completed, coordinated, and certified a comprehensive resident assessment;

(3) A person licensed as a social worker, or higher degree of training and licensure, completed a social services evaluation that meets the criteria in 42 CFR 456.270 and 456.370;

(4) A physician established a written plan of care;

(5) All less restrictive alternatives or services to prevent or defer nursing facility care have been explored; and

(6) When the Department has determined necessary, health care professionals completed and submitted to the Department a psychological or psychiatric evaluation in accordance with 42 CFR 483.20(f). If an applicant is diagnosed with a condition related to a code within the International Classification of Diseases, 9th revision, Clinical Modification (ICD-9-CM) psychiatric code range, the inter-disciplinary team shall submit its determinations to the Department, including the behavior intervention program if the team determined one to be necessary. If the team determined that behavior intervention is unnecessary, it shall include evidence supporting the determination. All behavior intervention programs shall:

(a) be a precisely planned systematic application of the methods and experimental findings of behavioral science with the intent of reducing observable negative behaviors;

(b) incorporate processes and methodologies that are the least restrictive alternatives available for producing the desired outcomes;

(c) be conducted only following identification and, if feasible, remediation of environmental and social factors that are likely to be precipitating or reinforcing the inappropriate behavior;

(d) incorporate a process for identifying and reinforcing a desirable replacement behavior;

(e) include a program data sheet;

(f) include a behavior baseline profile consisting of all of the following: the applicant's name; the date, time, location, and specific description of the undesirable behavior exhibited; the persons present and the conditions existing prior to and at the time of the undesirable behavior; the interventions used and their results; and the recommendations for future action; and

(g) include a behavior intervention plan consisting of all of the following: the applicant's name; the date the plan is prepared and when it will be used; the objectives stated in terms of specific behaviors; the names, titles, and signatures of the persons responsible for conducting the plan; and the methods and frequency of data collection and review.

R414-502-5. Criteria for Nursing Facility II Care.

The following criteria must be met before the Department may authorize Medicaid coverage for an applicant at the nursing facility II care level:

(1) The applicant meets all the criteria for nursing facility III care;

(2) The required intensity of services needed is less than that for skilled care; and

(3) The applicant has documented service needs for at least one of the following:

(a) Daily rehabilitative or restorative services provided under the direction of licensed professional staff, with documented measurable outcomes of treatment;

(b) Close observation, documentation, and follow-through to establish the impact of specified services, such as services to applicants with neurological involvement, hospice services, diabetes control, or dialysis, any one of which may utilize laboratory services and physician intervention;

(c) Training in personal care services to minimize dependency on staff for completion of activities of daily living;

(d) A behavior intervention program established because of specified aberrant behavior such as wandering, excessive sexual drive, destructive or aberrant acting out, prolonged depression leading to self-isolation or violent acts;

(e) Specialized nursing services for skin and wound care;

(f) Extensive interaction with professional staff to assist the applicant and family through the final three months of his anticipated life expectancy;

(g) Any skilled services ordered and given more frequently than two times each week, but less frequently than required for skilled care;

(h) Alzheimer's disease, senile dementia, organic brain disorder, and other diagnosed disease processes that use specialized documented programs that increase staff intervention in an effort to enhance the applicant's quality of life and functional and cognitive status;

(i) Multi-drug resistant, non-compliant tuberculosis applicants in the active phases of tuberculosis who are court ordered as a public health or communicable disease placement; or

(j) A diagnosis of mental retardation with a Level II determination indicating that the applicant can benefit from specialized rehabilitative services. The Department shall pay a provider for services provided for an applicant in this category an individual add-on rate depending on the specialized rehabilitative services provided to meet his needs.

R414-502-6. Criteria for Nursing Facility I Care.

The following criteria must be met before the Department may authorize Medicaid coverage for an applicant at the nursing facility I care level:

(1) The applicant meets all the criteria for nursing facility II care;

(2) The services are provided by a nursing facility certified pursuant to 42 CFR 442.101 through 442.110, or a swing bed hospital approved by the federal Health Care Financing Administration to furnish nursing facility I care in the Medicare program;

(3) The applicant has exhausted Medicare benefits or has been denied by Medicare for reasons other than level of care requirements;

(4) The applicant requires specialized and complex care documented in the applicant's medical record; and

(5) The criteria in 42 CFR 409.31 through 409.35, requirements for coverage of post-hospital skilled nursing facility care, are satisfied.

R414-502-7. Criteria for Intensive Skilled Care.

The following criteria must be met before the Department may authorize Medicaid coverage for an applicant for intensive skilled care:

(1) The applicant meets all the criteria for nursing facility I care. However, the following routine skilled care does not qualify as intensive skilled care under R414-502-6(5) in making a determination under this section:

(a) skilled nursing services described in 42 CFR 409.33(b);

(b) skilled rehabilitation services described in 42 CFR 409.33(c);

(c) routine monitoring of medical gases after a therapy regimen;

(d) routine levin tube and gastrostomy feedings; and

(e) routine isolation room and techniques.

(2) The applicant has exhausted Medicare benefits or has been denied by Medicare for reasons other than level of care requirements;

(3) The applicant requires and receives at least five hours daily of direct licensed professional nursing care, including a combination of specialized care and services, and assessment by a registered nurse and observation on a 24-hour basis; (4) The attending physician has made any one of the following determinations:

(a) there is presently no reasonable expectation that the applicant will benefit further from any care and services available in an acute care hospital that are not available in a nursing facility;

(b) the applicant's condition requires physician follow-up at the nursing facility at least once every 30 days; or

(5) An interdisciplinary team may indicate a therapeutic leave of absence from the nursing facility is appropriate either to facilitate discharge planning or to enhance the applicant's medical, social, educational, and habilitation potential;

(6) Except in extraordinary circumstances, the applicant has been hospitalized immediately prior to admission to the nursing facility;

(7) The applicant has been continuously approved for skilled care, either through Medicare or Medicaid, since admission to the nursing facility;

(8) The attending physician has written and signed progress notes at the time of each physician visit reflecting the current medical condition of the applicant; and

(9) If an applicant was previously approved for intensive skilled care and later downgraded to a lower care level, then, even though he was not discharged from a hospital, he may return to intensive skilled care instead of being hospitalized in an acute care setting if:

(a) a complication occurs involving the condition for which he was originally approved for intensive skilled care; and

(b) it has been less than 30 days since the termination of the previous intensive skilled care.

R414-502-8. Criteria for Intermediate Care for the Mentally Retarded.

The following criteria must be met before the Department may authorize Medicaid coverage for an applicant in an intermediate care facility for the mentally retarded:

(1) The applicant is mentally retarded, except that even if the applicant is mentally retarded, he will not qualify for care in an intermediate care facility for the mentally retarded if the applicant is ambulatory, continent, only moderately or mildly mentally retarded without complicating conditions, is in need of less than weekly intervention by or under the supervision of a health care professional or trained habilitative personnel, and is capable of daily attendance in work settings or day treatment. Day treatment is training and habilitation services outside the nursing facility that are:

(a) intended to aid the self-help and self-sufficiency skill development of a mentally retarded resident;

(b) sufficient to meet the specialized rehabilitative service requirements of 42 CFR 435.1009 for the mentally retarded; and

(c) coordinated with the active treatment program of the intermediate care facility for the mentally retarded.

(2) The appropriate local office of the Department of Human Services:

(a) informs the applicant or his legal representative of any feasible alternatives available under the home and community based services waiver, and gives him the choice of either nursing facility or home and community based services; and

(b) states in writing that without home and community based services, the applicant would require the level of care provided in an intermediate care facility for the mentally retarded; and

(3) The applicant has at least one of the following conditions:

(a) Is severely or profoundly retarded;

(b) Is under six years of age; (c) Is severely multiply handicapped in that he has at least two of the conditions identified in the definition of mental retardation found in the Diagnostic and Statistical Manual of Mental Disorders III (DSM-III-R), revised 1987;

(d) More than once per week is physically aggressive or assaultive towards himself or others;

(e) Is a security risk or wanders away at least once per week;

(f) Is diagnosed as severely hyperactive;

(g) Demonstrates psychotic-like behavior; or

(h) Has conditions requiring at least weekly intervention by or under the supervision of a health care professional or trained habilitative personnel.

KEY: medicaid
1994

26-1-5
26-18-3
63-46a-7(1)(a)

6 - 4 Preadmission Screening and Annual Resident Review

R414-503 of the Utah Administrative Code (UAC) implements requirements for the preadmission screening and annual review of nursing facility residents with serious mental illness or mental retardation. The text of R414-503 is reprinted below.

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.

R414-503. Preadmission Screening and Annual Resident Review.

R414-503-1. Introduction and Authority.

This rule implements 42 USC 1396r(b)(3)(f) and (e)(7) that require preadmission screening and annual review of nursing facility residents with serious mental illness or mental retardation.

R414-503-2. Definitions.

The definitions in R414-1-1 and R414-501-2 apply to this rule.

R414-503-3. Preadmission Level I Screening for All Persons.

The purpose of the preadmission Level I screening is to determine if a person seeking admission to a nursing facility has serious mental illness or mental retardation and is therefore subject to a Level II evaluation.

(1) A nursing facility may not admit a person unless a health care professional has completed a Level I screening. The Department shall deny reimbursement for a resident if a nursing facility fails to assure that the resident's Level I screening is completed as required.

(2) A health care professional shall complete a Level I screening on a form supplied by the Department and shall include the date of the screening and the signature of the health care professional completing the screening.

(3) If the Level I screening identifies a positive response to all of the following three criteria, then the screening shall conclude that the person may have a serious mental illness. The Level I screening criteria for serious mental illness are whether the person has:

(a) A diagnosis falling within the diagnostic codes of serious mental illness, as described in the Diagnostic and Statistical Manual of Mental Disorders III, Revised, 1987;

(b) Experienced a functional limitation in a major life activity within the last six months in that the person has serious difficulty on a continuing or intermittent basis in interpersonal functioning, concentration and persistence and pace, or adaptation to change, and which is due to the serious mental illness diagnosis;

(c) A treatment history indicating psychiatric treatment more intensive than outpatient care occurring more than once within the last two years; or experienced, within the last two years, significant disruption to his normal living situation to the degree that he required supportive services to maintain his current level of functioning at home or in a residential treatment environment; or required intervention by housing or law enforcement officials.

(4) If the Level I screening identifies at least one positive response to any of the following criteria then the screening shall conclude that the person may have mental retardation. The Level I screening criteria for mental retardation is whether the person has:

(a) A diagnosis of mental retardation;

(b) A current prescription for anti-convulsant medications for epilepsy with an onset prior to age 22;

(c) A history of mental retardation, or cognitive or behavioral indicators that the person has mental retardation; or

(d) Been referred by any agency specializing in the care of persons with mental retardation;

(5) If the screening does not indicate the person may have serious mental illness or mental retardation, or if the screening determines the person has a diagnosis of dementia (including Alzheimer's disease or an organic mental disorder) based on criteria in the Diagnostic and Statistical Manual of Mental Disorders III, Revised, 1987, then no further evaluation is necessary.

(6) If the person is admitted to a nursing facility, the nursing facility shall submit a copy of the Level I screening to the Department and shall retain a copy of the Level I screening in the resident's medical record.

(7) If the Level I screening indicates the person may have serious mental illness or mental retardation, then the Level I screener shall complete a notice of referral to the state authority that shall conduct the Level II evaluation. The notice shall be on a form provided by the Department. The screener shall give the notice to the person, his legal representative, and the nursing facility.

R414-503-4. Preadmission Level II Evaluation.

(1) The purposes of the preadmission Level II evaluation are to determine whether a person with serious mental illness or mental retardation who seeks admission to a nursing facility requires the level of services provided by a nursing facility and whether the person requires specialized services.

(2) If a Level I screening indicates a Level II evaluation is required, then a nursing facility may not admit the person unless the Level II evaluation is completed and determines that it is appropriate to place the person in a nursing facility. The Level II evaluation is not required for a person who is any one of the following:

(a) A provisional admission in which the person has delirium where an accurate diagnosis cannot be made until the delirium clears, or in emergency situations where the nursing facility placement will not exceed seven days. However, if the placement exceeds seven days, the Level II evaluation shall be completed;

(b) Readmitted to a nursing facility after being transferred to a hospital, or for a person who is transferred from one nursing facility to another operated by the same provider, with or without an intervening hospital stay; or

(c) Admitted to a nursing facility directly from a hospital where the person received acute inpatient care, and the person requires nursing facility services for the condition treated in the hospital, and the attending physician certifies before admission to the nursing facility that the person is likely to require a stay of less than 30 days. If a resident enters a nursing facility through such an exempted hospital discharge and then remains in the nursing facility for more than 30 days, then the resident shall be referred to the state mental health or mental retardation authority for an annual resident review within 40 calendar days of admission.

(3) The Department shall deny reimbursement for a resident if the nursing facility fails to assure that the resident's Level II evaluation is completed as required.

(4) If the Level I screening indicates the person may have mental retardation, then the person shall be referred to the Department of Human Services Division of Services for People with Disabilities for the Level II determination. If the Level I screening indicates the person may have a serious mental illness, then the person shall be referred to the Department of Human Services Division of Mental Health for the Level II determination. If the Level I screening indicates the person may have both a serious mental illness and mental retardation, then the person shall be referred to both divisions.

(5) The Level II evaluation shall be based on the criteria established pursuant to 42 USC 1396r(f)(8), and addressing the level of nursing services, specialized services, and specialized rehabilitative services needed. Based on those criteria, the Level II evaluation shall make one of the following six determinations:

(a) The person does not need nursing facility services. This determination disqualifies the person for placement in a nursing facility and Medicaid reimbursement;

(b) The person does not need nursing facility services but needs specialized services. This determination disqualifies the person for placement in a nursing facility and Medicaid reimbursement;

(c) The person needs nursing facility services but does not need specialized services. This determination qualifies the person for placement in a nursing facility and Medicaid reimbursement;

(d) The person is not a danger to himself or others and is being released from an acute care setting and requires a medically prescribed period of convalescent care in a nursing facility. This determination qualifies the person for placement in a nursing facility and Medicaid reimbursement for a period not to exceed 120 days with a categorical Level II evaluation. However, if the placement exceeds 120 days, the Level II evaluation shall be completed;

(e) The person is not a danger to himself or others and is certified by a physician to be terminally ill (a medical prognosis of a life expectancy of less than six months) and requires continuous nursing care or medical supervision or treatment due to a physical condition. The nature and extent of the person's need for nursing care, medical supervision, and medical treatment shall be the determining factors, and the existence of a chronic mental or physical disability shall be incidental considerations. This determination qualifies the person for placement in a nursing facility and Medicaid reimbursement with a categorical Level II evaluation; or

(f) The person has a severe physical illness that results in a level of impairment so severe that the recipient could not be expected to benefit from specialized services, like a categorical determination such as coma, ventilator dependence, or functioning at brain stem level, or a diagnosis such as chronic obstructive pulmonary disease, Parkinson's disease, Huntington's disease, amyotrophic lateral sclerosis, or congestive heart failure. This determination qualifies the person for placement in a nursing facility and Medicaid reimbursement with a categorical Level II evaluation.

(6) If at any time during the Level II evaluation the evaluator determines that the person does not have serious mental illness or mental retardation, or has a primary diagnosis of dementia without mental retardation, then the Level II evaluation may be stopped.

(7) The person or agency doing the evaluation shall provide a copy of the Level II determination and findings to the person evaluated, his legal representative, his attending physician, the discharging hospital, the nursing facility for retention in the person's medical record, if admitted, and to the Department prior to Medicaid reimbursement.

R414-503-5. Annual Resident Review.

(1) As long as a resident who requires a preadmission Level II evaluation continues to reside in a nursing facility, he shall have an annual resident review subject to the same requirements as the preadmission Level II evaluation. The Level II evaluator shall establish the annual review date at the time the preadmission Level II evaluation is completed. For administrative purposes, the annual review shall be defined as occurring within every fourth quarter after the previous preadmission screen or annual resident review. In order to avoid duplicative testing and effort, the annual resident review shall be coordinated with the routine resident assessments that are otherwise required.

(2) If a Level II evaluation determines a resident is no longer qualified for continued placement in a nursing facility, the nursing facility, in consultation with the resident and his legal representative, shall arrange for the safe and orderly discharge of the resident from the nursing facility, and prepare and orient the resident for the discharge.

R414-503-6. Out-of-State Arrangements.

The state in which the person is a resident (or would be a resident at the time he becomes eligible for Medicaid), as defined in 42 CFR 435.403, shall pay for the Level II evaluation in accordance with 42 CFR 431.52(b).

KEY: medicaid

1994 **26-1-5**

26-18-3

63-46a-7(1)(a)

6 - 5 Preadmission Screening and Annual Resident Review Identification Screen

The Preadmission Screening and Annual Resident Review Identification Screen which follows is the document to be used in the Level I screening process.

STATE OF UTAH

Preadmission Screening and Resident Review
Identification Screening
(Level I - ID Screen)

INSTRUCTIONS FOR FILLING OUT ID SCREEN

1. ID SCREEN MUST BE COMPLETED PRIOR TO ADMISSION TO MEDICARE/MEDICAID CERTIFIED NURSING HOME, REGARDLESS OF THE PAYMENT SOURCE.

2. PAGES 4 AND 5 MUST BE READ, AND QUESTIONS ANSWERED *BEFORE* **SECTIONS A** AND **B** ON *PAGE 3* ARE COMPLETED.

3. FILL OUT PAGE 3 THROUGH 5 COMPLETELY, KEEP THIS FORM WITH THE PATIENT'S MEDICAL RECORDS.

IF A PREADMISSION/CONTINUED STAY INPATIENT CARE TRANSMITTAL (10A) FORM IS SENT TO THE RESIDENT ASSESSMENT SECTION FOR MEDICAID REIMBURSEMENT, PLEASE COPY PAGES 3, 4, AND 5, SEND WITH TRANSMITTAL TO:

UTAH DEPARTMENT OF HEALTH
RESIDENT ASSESSMENT SECTION
288 NORTH 1460 WEST
P.O. BOX 142905
SALT LAKE CITY, UT 84114-2905

IF YOU HAVE QUESTIONS, PLEASE CALL RESIDENT ASSESSMENT Department AT 538-6158, OR TOLL FREE AT 1-800-662-4157.

THE LOCAL PASRR OFFICES FOR SMI ASSESSMENTS ARE:

1. Salt Lake, Summit, and Tooele counties: 801-567-3663
2. Box Elder, Cache, Rich, Morgan, and Weber counties: 801-625-3840
3. Wasatch and Utah counties: 801-373-7394
4. Davis County: 801-773-7060
5. Washington County: 435-634-5600
6. Iron County: 435-586-8226
7. Kane, Garfield and Beaver counties: 435-676-8176
8. Carbon, Daggett, Duchesne, Emery, Grand, Juab, Millard, Piute, San Juan, Sanpete, Sevier, Uintah, and Wayne counties: 435-654-6465.

STATE DIVISION OF MENTAL HEALTH/PASRR SECTION 801-538-9857

STATE DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES/PASRR SECTION FOR MENTAL RETARDATION OR DEVELOPMENTAL DISABILITY ASSESSMENTS 801-538-4209

THE LEVEL-1 ID SCREEN WILL BE BASED ON FEDERAL MINIMUM CRITERIA REQUIRED UNDER SECTION 1929(b)(3)(f) OF THE SOCIAL SECURITY ACT AND MUST, AT A MINIMUM, INCLUDE AN EVALUATION OF THE FOLLOWING CRITERIA TO DETERMINE IF THE APPLICANT/RESIDENT HAS A POSSIBLE SERIOUS MENTAL ILLNESS AND/OR MENTAL RETARDATION/DEVELOPMENTAL DISABILITY.

Revised 5/98

NOTICE OF REFERRAL FOR
PREADMISSION SCREENING RESIDENT REVIEW (PASRR)
LEVEL - II EVALUATION

NAME: _____

SOCIAL SECURITY NUMBER: _____ - _____ - _____

This is to inform you and your legal representative that you have received a positive PASRR Level-I identification screen (ID Screen) for the licensed health care professional signing this notice.

A positive Level-I ID Screen indicates you have a diagnosis of mental illness or mental retardation/developmental disability. This requires a referral for a Level-II evaluation.

When the PASRR Level-I Screen is positive, a PASRR Level-II evaluation must be done prior to admission to a Medicaid certified nursing facility, regardless of the source of payment.

You will be contacted by a representative from either the Division of Mental Health or the Division of Services for People with Disabilities, to arrange for the PASRR Level-II evaluation.

If you have questions regarding this notice, please contact the Level-I ID Screen evaluator.

_____
Signature: Level-I ID Screen Evaluator & Phone Number

_____
Date

cc: Legal Representative

PREADMISSION SCREENING RESIDENT REVIEW
IDENTIFICATION (ID) SCREENING
DOCUMENT NUMBER

Screening Date: _____ / _____ / _____
MM DD YY

Name: _____ Soc. Sec. No.: _____ - _____ - _____
LAST, FIRST, MI

DOB: _____ / _____ / _____ Medicaid#: _____ Medicare#: _____
MM DD YY

Facility: _____ Admission Date: _____ / _____ / _____
MM DD YY

Residence: _____
Address City State Zip

Placement prior to Request for Nursing Facility: _____

Nursing Facility Payment Source: _____

THIS SECTION TO BE FILLED OUT BY A LICENSED HEALTH PROFESSIONAL: I certify that the above information is true and correct to the best of my knowledge and is adequately documented in the applicant/resident case record.

_____
PLEASE PRINT NAME AND TITLE OF PROFESSIONAL

_____ _____ _____ / _____ / _____
Signature Title MM DD YY

SECTION A: Current Medical Diagnosis (with ICD-9 Coding)

1. (____.____) _____ 4. (____.____) _____
2. (____.____) _____ 5. (____.____) _____
3. (____.____) _____ 6. (____.____) _____

SECTION B: Psychiatric Diagnosis (with ICD-9 Coding)

1. (____.____) _____ 2. (____.____) _____

Instructions on page 4 indicate a Serious Mental Illness (SMI) YES ( ) NO ( )

Diagnosis of Mental Retardation/Developmental Disability (with ICD-9 Coding)

1. (____.____) _____ 2. (____.____) _____

***THE APPLICANT HAS BOTH A SMI AND MR/DD DIAGNOSIS: YES ( ) NO ( )**
Instructions on page 5 indicate a Mental Retardation/Developmental Disability YES ( ) NO ( )

REFERRED FOR PASRR LEVEL-II DATE: _____ / _____ / _____
MM DD YY

NAME OF PERSON AND AGENCY CONTACTED: _____

PASRR EXEMPTION/HOSPITAL TRANSFER ONLY: DISCHARGE M.D. HAS CERTIFIED IN WRITING, THE NURSING FACILITY STAY IS ANTICIPATED TO BE LESS THAN 30 DAYS. YES ( ) NO ( )

LEVEL I REVISION DUE TO: _____ **DATE:** _____ / _____ / ___
MM DD YY

SIGNATURE: _____

*Call both Mental Health & MR/DD PASRR Programs

SERIOUS MENTAL ILLNESS
CATEGORIES AND CRITERIA

Schizophrenia and Other Psychotic Disorders

Depression or Bipolar Disorders

Delusional Disorder

Panic or Other Severe Anxiety Disorders

Somatization Disorders

Borderline Personality Disorder

THE APPLICANT/RESIDENT REQUIRES A REFERRAL FOR A PASRR LEVEL-II ASSESSMENT WHEN:

1. THERE IS A CURRENT SMI DIAGNOSIS OR WITHIN THE PAST YEAR, THERE HAVE BEEN SYMPTOMS OF A SERIOUS MENTAL ILLNESS THAT FALL INTO THE ABOVE CATEGORIES, **AND IF ANY** OF THE QUESTIONS BELOW ARE MARKED YES.

2. THIS SMI DIAGNOSIS PREDATES THE ONSET OF ANY ORGANIC MENTAL DISORDER (I.E., CVA, DEMENTIA, MENTAL DISORDER DUE TO A GENERAL MEDICAL CONDITION, ETC.)
   YES _____ NO _____

3. THIS PERSON IS CURRENTLY RECEIVING, OR IN THE PAST YEAR HAS BEEN PRESCRIBED AN ANTIPSYCHOTIC, ANTIDEPRESSANT OR ANTIANXIETY MEDICATION FOR A SMI.
   YES _____ NO _____

COMMENTS: _____

MENTAL RETARDATION
DEVELOPMENTAL DISABILITY
CRITERIA

REFER FOR A PASRR LEVEL-II ASSESSMENT IF ANY OF THE FOLLOWING ARE MARKED YES.

THE RESIDENT APPLICANT HAS A DIAGNOSIS OF MENTAL RETARDATION

YES ( ) NO ( )

IF YES, LIST DIAGNOSIS: _____

_____ **OR**

THE RESIDENT/APPLICANT HAS A DIAGNOSIS OF A RELATED CONDITION; I.E., CEREBRAL PALSY, TRAUMATIC BRAIN INJURY, EPILEPSY/SEIZURES, OR AUTISM, (THIS IS NOT AN ALL- INCLUSIVE LIST), OR DEVELOPMENTAL DELAYS, WHICH INCLUDES A HISTORY OF FUNCTIONAL LIMITATIONS RELATED TO THAT CONDITION WHICH:

C. OCCURRED PRIOR TO HIS/HER 22nd BIRTHDAY YES ( ) NO ( )

D. IS LIKELY TO CONTINUE THROUGHOUT HIS/HER LIFE YES ( ) NO ( )

E. HAS RESULTED IN SIGNIFICANT FUNCTIONAL DEFICITS YES ( ) NO ( )

COMMENTS: _____

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7 PROGRAM CERTIFICATION AND RESIDENT ASSESSMENT

7 - 1 Program Survey and Certification

Requirements related to program survey and certification are contained in State Operations Manual transmittals 273, 274 and 277. Copies of these transmittals can be obtained from the Bureau of Medicare/Medicaid Program Certification and Resident Assessment.

7 - 2 Alternative Remedies for Nursing Facilities

R414-7C of the Utah Administrative Code (UAC) provides for the imposition of alternative remedies as the result of on-site inspection findings. The text of R414-7C is reprinted below.

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.

R414-7C. Alternative Remedies for Nursing Facilities.

R414-7C-1. Authority and Purpose.

(1) The Department conducts on-site inspections of nursing facilities to determine compliance with state and federal Medicaid standards. When the Department finds that a nursing facility is out of compliance with requirements of participation, the Department may apply remedies to eliminate deficiencies and bring the facility into compliance.

(2) Authority to apply the remedies described in this section is defined in the federal Omnibus Budget Reconciliation Act (OBRA) of 1987 (P.L. 100-203), which mandates compliance with requirements of participation for the Medicaid program, and in Section 26-18-3 of the Utah Code Annotated 1953. Section 1919(h) of the Social Security Act specifies remedies available to a state when a skilled nursing facility (SNF) or nursing facility (NF) is out of compliance with the requirements for participation in the Medicaid program. This section requires the state to ensure prompt compliance, and it further specifies that the available remedies are in addition to other remedies available under state or federal law and, except for fines, are imposed prior to the conduct of a hearing.

(3) This rule establishes criteria for the imposition of remedies authorized by statute.

(4) The Department adopts and incorporates by reference the regulations in 42 CFR, Part 488-Survey, Certification, and Enforcement Procedures, as amended in the Federal Register for November 10, 1994, 59 FR 56237.

R414-7C-2. Civil Fines.

(1) Interest shall be assessed on the unpaid balance of the fine, beginning on the due date. The interest rate charged shall be the average of the bond equivalent of the weekly 90-day U.S. treasury bill auction rates during the period for which interest will be charged.

(2) Disposition of Fines Collected.

(a) The Department shall deposit fines and corresponding interest collected from Medicaid certified facilities in the General Fund in accordance with Section 26-18-3(5) of the Utah Code Annotated (UCA).

(b) Fines collected by the Department must be applied in accordance with Section 1919 of the Act for the protection of the health and property of residents.

KEY: medicaid
1997

26-1-4.1
26-1-5
26-18-3

7 - 3 Minimum Data Set (MDS)

All certified Medicare or Medicaid nursing facilities must complete, record, encode and transmit the Minimum Data Set (MDS) for all residents in the facility, regardless of age, diagnosis, length of stay or payment category. MDS requirements do not apply in the following situations:

A. Unless otherwise required by the State, licensed-only nursing facilities that do not participate in either Medicare or Medicaid.

B. Unless otherwise mandated by the State, individuals residing in non-certified units of nursing facilities.

Appendix F contains the Minimum Data Set (MDS) form.

8 BILLING and REIMBURSEMENT

8 - 1 LTC Turnaround Document

The long term care claim is called the “turnaround” document or TAD. This document is sent to the facility monthly with items 1 through 12 completed for each claim (Medicaid resident). There is space for 5 claims on each page for 5 different recipients. Appendix C contains the turnaround document and instructions.

9 PAYMENT RATES and COST PROFILING

9 - 1 Nursing Facility Reimbursement

The Utah State Plan, Attachment 4.19-D, provides details concerning nursing facility reimbursement for services after June 30, 1981. Appendix G contains this portion of the state plan.

INDEX

Brochures - see Publications
Pamphlets - see Publications
MDS - see Minimum Data Set
ORS - see Office of Recovery Services
PASRR - see Preadmission Screening
SNFS - See Skilled Nursing Facilities
UAC - See Utah Administrative Code
UCA - See Utah Code Annotated
For other acronyms, refer to the list at the end of SECTION 1, General Information.